

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11516**
Registrar's No. **101**

FILED APR 20 1948

Registration District No. **32**

Primary Registration District No. **3006**

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Columbia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Wilhite Convalescent Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11 Months** (Specify whether
in this community **11 Months** years, months or days)

3. (a) PRINT FULL NAME **ALBERT ERNEST WINN**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **11 - 3 - 1873** (Month) (Day) (Year)

8. AGE: Years **74** Months **5** Days **0** If less than one day hr. min.

9. Birthplace **Boone County Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER { 12. Name **A.H. Winn** ()
13. Birthplace **Boone County Missouri** (City, town, or county) (State or foreign country)
14. Maiden name **Eliza Riggs** ()
15. Birthplace **Boone County Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Charles Winn**

(b) Address **Columbia, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4-4-48** (Month) (Day) (Year)

(c) Place: burial or cremation **Friendship Cemetery**

18. (a) Signature of funeral director **Parker Funeral Service**

(b) Address **Columbia, Mo.**

19. (a) **4-5-48** (Date received local registrar) (b) **Mrs. R.E. Palmer** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone** (c) City or town **Hallsville** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **3** year **1948** hour **7** minute **A.** M.

21. I hereby certify that I attended the deceased from **on 4-2-48** to **on 4-2-48**
that I last saw him alive on **4-2-48** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction** Duration _____
Not known
One cerebral artery
Had only one leg.
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None** Of autopsy **None** PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **No** (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature **W.H. Dyer** (M. D. or other) **M.D.**
Address **Columbia, Mo.** Date signed **4-5-48**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 2
District File Number
Date Filed APR 19 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{Not} embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Tom M. Harg

Licensed Embalmer No. 4867

P. O. Address Columbia Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.